AILSA SURGERY

42 ADMIRAL STREET, GLASGOW, G41 1HU

Date:_____

NEW PATIENT REGISTRATION - PLEASE COMPLETE

SURNAME:				
FIRST NAME:		TITLE:		
DATE OF BIRTH:	__ / __ /__	GENDER:	Male ☐ Female ☐	(tick box)
MARITAL STATUS:		OCCUPATION:		
ETHNICITY:	(This is a health board requirement)			
Interpreter required?	YES ☐ NO ☐	Language:		

CONTACT DETAILS

ADDRESS: Including flat no. POSTCODE:			
TELEPHONE NO:			
Are you happy to have messages left on this number?	YES ☐ NO ☐		
MOBILE NO:			
Are you happy to have messages left on this number?	YES ☐ NO ☐		
Do you consent to allow the practice to send non-clinical information by SMS to your mobile number?	YES ☐ NO ☐		
email address:			
NEXT OF KIN: Name/ Relationship/ Tel number:		Who else lives in this household?	
Do you regularly care for someone who is disabled or chronically ill?			YES ☐ NO ☐
Do you have a carer?	YES ☐ NO ☐	If yes, name of carer	

LIFESTYLE

SMOKING STATUS:	Never smoked ☐	Current Smoker ☐	Ex-smoker ☐
ALCOHOL:	Do you ever drink alcohol:		YES ☐ NO ☐
If yes, how much to you drink per week?	Wine: _____	Beer / Lager: _____	Spirits: _____
EXERCISE:	Do you take regular exercise:		YES ☐ NO ☐
If yes, what type of Exercise, duration and frequency	(eg – cycling for 30 mins twice a week)		

Updated 6/3/19

MEDICATION

Are you on any regular medication? Please list below		
DRUG NAME:	STRENGTH:	FREQUENCY

ALLERGIES

DRUG NAME:	Type of reaction – eg rash, muscle pain etc

MEDICAL HISTORY

Does the person registering have any of the following conditions?			
High blood pressure	YES ☐ NO ☐	Asthma	YES ☐ NO ☐
Stroke / TIA	YES ☐ NO ☐	COPD	YES ☐ NO ☐
Heart Disease	YES ☐ NO ☐	Epilepsy	YES ☐ NO ☐
Diabetes	YES ☐ NO ☐	Heart Failure	YES ☐ NO ☐
Dementia	YES ☐ NO ☐	Mental Health illness	YES ☐ NO ☐

OTHER DIAGNOSES & OPERATIONS

Have you had any serious illness, accident or operations, x-rays or similar tests?	
Please list below	APPROX DATE

FAMILY HISTORY

Has a first degree relative (parent or sibling) suffered from the following:		
Disease:	Tick box:	Mother/Father Brother/Sister
Cancer:	YES ☐ NO ☐	
Heart Disease:	YES ☐ NO ☐	
Stroke / TIA:	YES ☐ NO ☐	
Diabetes:	YES ☐ NO ☐	
High Blood Pressure:	YES ☐ NO ☐	
Asthma:	YES ☐ NO ☐	
Other serious illness:		

VACCINATIONS

Which vaccinations have you had and when:			
Vaccine:	Approx date:	Vaccine:	Approx date:
Diphtheria:		Cholera:	
Polio:		Yellow Fever:	
Tetanus:		Whooping cough:	
Typhoid:		Shingles:	
Measles:		Pneumococcal:	
BCG:		Flu:	
MMR:		German Measles:	
Hep A		Hep B	
Men C		Rabies	

FEMALES ONLY

Date of last smear:		Result:	
How many children?		Ages of children:	
Have you had a miscarriage?	YES ☐ NO ☐	Date:	
Have you had a hysterectomy?	YES ☐ NO ☐	Date:	
Which method of contraception are you using at present?			
Are you currently pregnant?		YES ☐ NO ☐	LMP:

ETHNIC MONITORING

NAME: _____ **DATE OF BIRTH**: _____

Ethnic Group:

A. White

- ☐ Scottish
- ☐ Other British
- ☐ Irish
- ☐ Any other white background (specify) _____

B. Mixed

- ☐ Any mixed background (specify) _____

C. Asian, Asian Scottish, Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background (specify) _____

D. Black, Black Scottish or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background (specify) _____

E. Other ethnic background

- ☐ Any other ethnic background (specify) _____

F. Other

- ☐ Prefer not to say
- ☐ If you do not know your ethnicity, tick here.